This Amended Findings and Decision supercedes all previous decisions rendered in this matter.

The Medical Review Division's Findings and Dismissal of April 18, 2003, was issued in error and subsequently withdrawn by the Medical Review Division. The case was dismissed based upon Rule 133.304 because the bills were not properly submitted to the insurance carrier for reconsideration. The documentation submitted for review supports that the respondent reviewed the bills in a second EOB audit that resulted in "S" supplemental payment. Since, the hospital bills went through the reconsideration process, the hospital bills are eligible for review by the Medical Review Division. The original Findings and Dismissal, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1.

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 8-16-02.

I. DISPUTE

Whether there should be additional reimbursement for inpatient hospitalization.

II. FINDINGS

a. Based on Commission Rule 133.307(d)(1-2), the only dates of service eligible for review are those commencing on 4-24-02 and extending through 4-27-02.

b. The Provider billed the insurance carrier $56,878.86.

c. The insurance carrier paid a total reimbursement of $21,249.90.

d. The insurance carrier based their reimbursement based upon, "M –No MAR," "N – Not Documented," and "S- Supplemental Payment."

e. Per the TWCC-60 the total amount in dispute is $21,409.25.

f. The claimant was admitted on 4-24-02 with a principal diagnosis of 722.10 for spinal surgery to ___.

III. RELEVANT STATUTE

a. Rule 134.401(b)(1)(B), "Inpatient services – Health care, as defined by the Texas Labor Code § 401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

b. Rule 134.401(b)(1)(F), "Stop-Loss Payment – An independent method of payment for an unusually costly or lengthy stay."

c. Rule 134.401(b)(1)(G), "Stop-Loss Reimbursement Factor (SLRF) – A factor established by the Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds."

d. Rule 134.401(b)(1)(H), "Stop-Loss Threshold (SLT) – Thresholds of total charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor by the total charges identifying that particular threshold."

e. Rule 134.401(c)(6), "Stop-Loss Method. Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of and not in addition to the per diem based reimbursement system. The diagnosis codes specified in (c)(5) are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate."

f. Rule 134.401(c)(5), "Reimbursement for Certain ICD-9 Codes. When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate:

    (A) Trauma (ICD-9 codes 800.0 – 959.50);
    (B) Burns (ICD-9 codes 940 – 949.9); and
    (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042 – 044.9)."

g. Rule 134.401(c)(6)(A)(i), "To be eligible for stop-loss payment for the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold."

h. Rule 134.401(c)(6)(A)(iii), "If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%.

i. Rule 134.401(c)(6)(A)(v), "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television). If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted. Items and services which are not related to the compensable injury may be deducted. The formula to obtain audited charges is as follows: Total Charges – Deducted Charges = Audited Charges.

j. Rule 134.401(c)(6)(B), "Formula. Audited Charges X SLRF – WCRA."

IV. RATIONALE

a. Based upon the EOB the total charges were $56,878.86 for inpatient hospitalization. Per Rule 134.401(c)(6)(A)(i), to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000. $56,878.86 exceeds $40,000; therefore, the stop-loss methodology applies to this admission.

b. The principal diagnosis noted on the UB-92 was 722.10. Per Rule 134.401(c)(6), diagnosis code 722.10 is not a diagnosis identified in section (c)(5). Therefore, the inpatient hospitalization is not exempt from the Stop-loss methodology.

c. The insurance carrier did not perform an on-site audit per Rule 134.401(c)(6)(A)(v).

d. Based upon the EOBs the insurance carrier based their payment on "M –No MAR," "N – Not Documented," and "S- Supplemental Payment." The insurance carrier did not reimburse the provider based upon correct methodology; therefore, was incorrect to deny based upon "M" and "S".

e. The requestor supported inpatient hospitalization; therefore, the insurance carrier was incorrect to deny reimbursement based upon "N".

f. Per Rule 134.401(c)(6), Stop-loss methodology shall be used in place of and not in addition to the per diem based reimbursement system. The insurance carrier did not reimburse the provider based upon stop-loss methodology.

g. Per Rule 134.401(c)(6)(B), the Stop-Loss Formula results in an appropriate reimbursement of $56,878.86 x 75% = $42,659.15.

h. Since the insurance carrier paid $21,249.90. The difference between appropriate reimbursement of $42,659.155 and amount paid of $21,249.90= $21,409.25.

Therefore, the requestor is entitled to additional reimbursement of $21,409.25.

The above Amended Findings and Decision are hereby issued this 10th day of September 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

V. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for inpatient hospitalization in the amount of $21,409.25**.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $21,409.25 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Amended Findings, Decision and Order are hereby issued 10th day of September 2003.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/ep